Plans entered into, amended or renewed on or after November 5, 1990, are subject to this section, as are prior plans that do not clearly exclude payment for services covered by this section.

[55 FR 21748, May 29, 1990, as amended at 57 FR 41101, Sept. 9, 1992]

§ 220.7 Remedies and procedures.

(a) Pursuant to 10 U.S.C. 1095(e)(1), the United States may institute and prosecute legal proceedings against a third party payer to enforce a right of the United States under 10 U.S.C. 1095 and this part.

(b) Pursuant to 10 U.S.C. 1095(e)(2), an authorized representative of the United States may compromise, settle or waive a claim of the United States under 10 U.S.C. 1095 and this part.

(c) The authorities provided by 31 U.S.C. 3701, *et seq.*, 28 CFR part 11, and 4 CFR parts 101–104 regarding collection of indebtedness due the United States shall be available to effect collections pursuant to 10 U.S.C. 1095 and this part.

(d) A third party payer may not, without the consent of a U.S. Government official authorized to take action under 10 U.S.C. 1095 and this part, offset or reduce any payment due under 10 U.S.C. 1095 or this part on the grounds that the payer considers itself due a refund from a facility of the Uniformed Services. A request for refund must be submitted and adjudicated separately from any other claims submitted to the third party payer under 10 U.S.C. 1095 or this part.

[55 FR 21748, May 29, 1990, as amended at 65 FR 7728, Feb. 16, 2000]

§ 220.8 Reasonable costs.

(a) *Diagnosis related group (DRG)-based method for calculating reasonable costs for inpatient services*—(1) *In general.* As authorized by 10 U.S.C. 1095(f)(3), the calculation of reasonable costs for purposes of collections for inpatient hospital care under 10 U.S.C. 1095 and this part shall be based on diagnosis related groups (DRGs). Costs shall be based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal diagnosis involved. The average cost per case shall be published annually as an inpatient standardized amount. A relative weight for each DRG shall be the same as the DRG weights published annually for hospital reimbursement rates under the Civilian Health and Medicare Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1).

(2) *Standardized amount.* The standardized amount shall be determined by dividing the total costs of all inpatient care in all military treatment facilities by the total number of discharges. This will produce a single national standardized amount. The Department of Defense is authorized, but not required by this part, to calculate three standardized amounts, one for large urban, other urban/rural, and overseas areas, utilizing the same distinctions in identifying the first two areas as is used for CHAMPUS under 32 CFR 199.14(a)(1). Using this applicable standardized amount, the Department of Defense may make adjustments for area wage rates and indirect medical education costs (as identified in paragraph (a)(4) of this section), producing for each inpatient facility of the Uniformed Services a facility-specific ''adjusted standardized amount'' (ASA).

(3) *DRG relative weights.* Costs for each DRG will be determined by multiplying the standardized amount per discharge by the DRG relative weight. For this purpose, the DRG relative weights used for CHAMPUS pursuant to 32 CFR 199.14(a)(1) shall be used.

(4) *Adjustments for outliers, area wages, and indirect medical education.* The Department of Defense may, but is not required by this part, to adjust cost determinations in particular cases for length-of-stay outliers (long stay and short stay), cost outliers, area wage rates, and indirect medical education. If any such adjustments are used, the method shall be comparable to that used for CHAMPUS hospital reimbursements pursuant to 32 CFR 199.14(a)(1)(iii)(E), and the calculation of the standardized amount under paragraph (a)(2) of this section will reflect that such adjustments will be used.

(5) *Identification of professional and hospital costs.* For purposes of billing

third party payers other that automobile liability and no-fault insurance carriers, inpatient billings will be subdivided into two categories:

(i) Hospital charges (which refers to routine service charges associated with the hospital stay and ancillary charges).

(ii) Professional charges (which refers to professional services provided by physicians and certain other providers).

(6) *Outpatient billings.* Outpatient billings (including those for ambulatory procedure visits) may, but are not required by this part, to be subdivided into two categories:

(i) Professional charges (which refers to professional services provided by physicians and certain other providers); and

(ii) Outpatient services (which refers to overhead and ancillary, diagnostic and treatment services, other than professional services provided in connection with the outpatient visit).

(b) *Unified per diem rates for care provided prior to October 1, 1992.* For inpatient hospital care provided prior to October 1, 1992, the computation of reasonable costs shall be based on the unified per diem full reimbursement rate for all clinical categories of hospital care. For purposes of this paragraph (and paragraph (c) of this section), charges for patients hospitalized before and after the October 1 start date shall be based on the determination method in effect for the respective periods of hospitalization.

(c) *Clinical groups per diem rates for care provided on or after October 1, 1992, and prior to October 1, 1994.* For inpatient hospital care provided on or after October 1, 1992, and prior to October 1, 1994, the computation of reasonable costs shall be based on the per diem full reimbursement rate applicable to the clinical category of services involved. Patients treated in an intensive care unit any time during the 24 hour nursing period shall be charged the intensive care per diem charge in lieu of a charge to the clinical service to which the patient is currently assigned. For this purpose, 12 clinical groups are established, as follows:

(1) Medical Care Services. This includes internal medicine, cardiology, dermatology, endocrinology, gastroenterology, hematology, nephrology, neurology, oncology, pulmonary and upper respiratory disease, rheumatology, physical medicine, clinical immunology, HIV III—Acquired Immune Deficiency Syndrome (AIDS), infectious disease, allergy, and medical care not elsewhere classified.

(2) Surgical Care Services. This includes general surgery, cardiovascular and thoracic surgery, neurosurgery, ophthalmology, oral surgery, otolaryngology, pediatric surgery, plastic surgery, proctology, urology, peripheral vascular, trauma service, head and neck service and surgical care not elsewhere classified.

(3) Obstetrical and Gynecological Care.

(4) Pediatric Care. This includes pediatrics, nursery, adolescent pediatrics and pediatric care not elsewhere classified.

(5) Orthopaedic Care. This includes orthopaedics, podiatry and hand surgery.

(6) Psychiatric Care and Substance Abuse Rehabilitation.

(7) Family Practice Care.

(8) Burn Unit Care.

(9) Medical Intensive Care/Coronary Care.

(10) Surgical Intensive Care.

(11) Neonatal Intensive Care.

(12) Organ and Bone Marrow Transplants.

(d) *Medical services and subsistence charges included.* Medical services charges pursuant to 10 U.S.C. 1078 or subsistence charges pursuant to 10 U.S.C. 1075 are included in the claim filed with the third party payer pursuant to 10 U.S.C. 1095. For any patient of a facility of the Uniformed Services who indicates that he or she is a beneficiary of a third party payer plan, the usual medical services or subsistence charge will not be collected from the patient to the extent that payment received from the payer exceeds the medical services or subsistence charge. Thus, except in cases covered by § 220.8(k), payment of the claim made pursuant to 10 U.S.C. 1095 which exceeds the medical services or subsistence charge, will satisfy all of the third party payer's obligation arising from the inpatient hospital care provided by

the facility of the Uniformed Services on that occasion.

(e) *Per visit rates.* (1) As authorized by 10 U.S.C. 1095(f)(2), the computation of reasonable costs for purposes of collections for most outpatient services shall be based on a per visit rate for a clinical specialty or subspecialty. The per visit charge shall be equal to the outpatient full reimbursement rate for that clinical specialty or subspecialty and includes all routine ancillary services. A separate charge will be calculated for cases that are considered ambulatory procedure visits. These rates shall be updated and published annually. As with inpatient billing categories, clinical groups representing selected board certified specialties/subspecialties widely accepted by graduate medical accrediting organizations such as the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Medical Specialties will be used for ambulatory billing categories. Related clinical groups may be combined for purposes of billing categories.

(2) The following clinical reimbursement categories are representative, but not all-inclusive of the billing category clinical groups referred to in paragraph (e)(1) of this section: Internal Medicine, Allergy, Cardiology, Diabetic, Endocrinology, Gastroenterology, Hematology, Hypertension, Nephrology, Neurology, Nutrition, Oncology, Pulmonary Disease, Rheumatology, Dermatology, Infectious Disease, Physical Medicine, General Surgery, Cardiovascular and Thoracic Surgery, Neurosurgery, Ophthalmology, Organ Transplant, Otolaryngology, Plastic Surgery, Proctology, Urology, Pediatric Surgery, Family Planning, Obstetrics, Gynecology, Pediatrics, Adolescent Pediatrics, Well Baby, Orthopaedics, Cast, Orthotic Laboratory, Hand Surgery, Podiatry, Psychiatry, Psychology, Child Guidance, Mental Health, Social Work, Substance Abuse Rehabilitation, Family Practice, and Occupational and Physical Therapy.

(f) *Ambulatory procedure visit rates.* A separate charge will be calculated for ambulatory procedure visits (APVs). APVs are same day surgery visits and other outpatient visits provided by designated, special treatment units in facilities of the Uniformed Services. APV rates shall be based on the total cost of immediate (day of procedure) pre-procedure; procedure; and immediate post-procedure care performed in the ambulatory procedure unit setting for care requiring less than 24 hours in the facility. An APV is not inpatient care. The Department of Defense is authorized, but not required by this part, to establish multiple ambulatory procedure visit reimbursement categories based on the clinic or subspecialty performing the ambulatory procedure. The average cost of APVs will be published annually.

(g) *Special rule for services ordered and paid for by a facility of the Uniformed Services but provided by another provider.* In cases where a facility of the Uniformed Services purchases ancillary services or procedures, from a source other than a Uniformed Services facility, the cost of the purchased services will be added to the standard rate. Examples of ancillary services and other procedures covered by this special rule include (but are not limited to): laboratory, radiology, pharmacy, pulmonary function, cardiac catheterization, hemodialysis, hyperbaric medicine, electrocardiography, electroencephalography, electroneuromyography, pulmonary function, inhalation and respiratory therapy and physical therapy services.

(h) *Special rule for ancillary services ordered by outside providers and provided by a facility of the Uniformed Services.* If a Uniformed Services facility provides certain ancillary services, prescription drugs or other procedures requested by a source other than a Uniformed Services facility and are not incident to any outpatient visit or inpatient services, the reasonable cost will not be based on the usual Diagnostic Related Group (DRG) or per visit rate. Rather, a separate standard rate shall be established based on the cost of the particular services, drugs, or procedures provided. Effective April 1, 2000, this special rule applies to all services, drugs or procedures ordered by an outside provider and provided by a facility of the Uniformed Services. For such ancillary services provided prior to April 1, 2000, this special rule applies only to services, drugs or procedures

having a cost of at least $25. The reasonable cost for the services, drugs or procedures to which this special rule applies shall be calculated and made available to the public annually.

(i) *Miscellaneous health care services.* Some outpatient services are provided which may not traditionally be provided in hospitals or which are not traditional clinical specialties or subspecialties. This includes, but is not limited to, land ambulance service, air ambulance service, hyperbaric treatments, dental care services and immunizations.

(1) The charge for ambulance services shall be based on the full costs of operating the ambulance service.

(2) For hyperbaric treatments (such as high pressure oxygenation treatments, burn treatments and decompression treatments in response to diving incidents), charges will be based on the full operating costs of the hyperbaric treatment services.

(3) Charges for dental services (including oral diagnosis and prevention, periodontics, prosthodontics (fixed and removable), implantology, oral surgery, orthodontics, pediatric dentistry and endodontics) will be based on a full cost of the dental services.

(4) The charge for immunizations, allergin extracts, allergic condition tests, and the administration of certain medications when these services are provided in a separate immunizations or shot clinic, will be based on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each immunization, injection or medication administered.

(j)(1) *Special rule for former Public Health Service facilities.* In connection with the former Public Health Service facilities described in § 220.12(c), the computation of reasonable costs for purposes of collections under 10 U.S.C. 1095 and this part may differ from such computations under § 220.8. Reasonable costs for such facilities shall be determined by the Department of Defense based on approximate government costs for similar services under CHAMPUS.

(2) The special rule set forth in paragraph (j)(1) of this section expires September 30, 1997. Effective October 1, 1997, collections for health care services provided by these facilities are no longer covered by this part, but are covered by 32 CFR 199.8 (CHAMPUS Double Coverage).

(k) *Special rules for TRICARE Resource Sharing Agreements and Partnership Program providers*—(1) *In general.* Paragraph (k) establishes special Third Party Collection program rules for TRICARE Resource Sharing Agreements and Partnership Program providers.

(i) TRICARE Resource Sharing Agreements are agreements under the authority of 10 U.S.C. 1096 and 1097 between uniformed services treatment facilities and TRICARE managed care support contractors under which the TRICARE managed care support contractor provides personnel and other resources to the uniformed services treatment facility concerned in order to help the facility increase the availability of health care services for beneficiaries. TRICARE is the managed care program authorized by 10 U.S.C. 1097 (and several other statutory provisions) and established by regulation at 32 CFR 199.17.

(ii) Partnership Program providers provide services in facilities of the uniformed services under the authority of 10 U.S.C. 1096 and the CHAMPUS program. They are similar to providers providing services under TRICARE Resource Sharing Agreements, except that payment arrangements are different. Those functioning under TRICARE Resource Sharing Agreements are under special payment arrangements with the TRICARE managed care contractor; those under the Partnership Program file claims under the standard CHAMPUS program on a fee-for-service basis.

(2) *Special rule for TRICARE Resource Sharing Agreements.* Services provided in facilities of the uniformed services in whole or in part through personnel or other resources supplied under a TRICARE Resource Sharing Agreement are considered for purposes of this part as services provided by the facility of the uniformed services. Thus, third party payers will receive a claim for such services in the same manner and for the same costs as any similar

services provided by a facility of the uniformed services. This paragraph (k)(2) becomes effective April 1, 1997.

(3) *Special rule for Partnership Program providers.* For inpatient services for which the professional provider services were provided by a Partnership Program participant, the professional charges component of the bill will be deleted from the claim from the facility of the uniformed services. In these cases, the uniformed service facility's claim shall not be considered solely a ''facility charge.'' As an all-inclusive bill, room and board, nursing services and all ancillary services (radiology, pharmaceuticals, respiratory therapy, etc.) are factored into the bill. The third party payer will receive a separate claim for professional services directly from the individual health care provider. The same is true for the professional services provided on an outpatient basis under the Partnership Program. Claims from Partnership Program providers are not covered by 10 U.S.C. 1095 or this part, but are governed by statutory and regulatory requirements of the CHAMPUS program.

(l) *Alternative determination of reasonable costs.* Any third party payer that can satisfactorily demonstrate a prevailing rate of payment in the same geographic area for the same or similar aggregate groups of services that is less than the standard rate (or other amount as determined under paragraphs (f) through (k) of this section) of the facility of the Uniformed Services may, with the agreement of the facility of the Uniformed Services (or other authorized representatives of the United States), limit payments under 10 U.S.C. 1095 to that prevailing rate for that aggregate category of services. The determination of the third party payer's prevailing rate shall be based on a review of valid contractual arrangements with other facilities or providers constituting a majority of the services for which payment is made under the third party payer's plan. This paragraph does not apply to cases covered by § 220.11.

[57 FR 41101, Sept. 9, 1992, as amended at 59 FR 49002, Sept. 26, 1994; 61 FR 6542, Feb. 21, 1996; 62 FR 941, Jan. 7, 1997; 65 FR 7728, Feb. 16, 2000]

§ 220.9 Rights and obligations of beneficiaries.

(a) *No additional cost share.* Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) *Availability of healthcare services unaffected.* The availability of healthcare services in any facility of the Uniformed Services will not be affected by the participation or nonparticipation of a Uniformed Services beneficiary in a health care plan of a third party payer. Whether or not a Uniformed Services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of healthcare services in a facility of the Uniformed Services.

(c) *Obligation to disclose information and cooperate with collection efforts.* (1) Uniformed Services beneficiaries are required to provide correct information to the facility of the Uniformed Services regarding whether the beneficiary is covered by a third party payer's plan. Such beneficiaries are also required to provide correct information regarding whether particular health care services might be covered by a third party payer's plan, including services arising from an accident or workplace injury or illness. In the event a third party payer's plan might be applicable, a beneficiary has an obligation to provide such information as may be necessary to carry out 10 U.S.C. 1095 and this part, including identification of policy numbers, claim numbers, involved parties and their representatives, and other relevant information.

(2) Uniformed Services beneficiaries are required to take other reasonable steps to cooperate with the efforts of the facility of the Uniformed Services to make collections under 10 U.S.C. 1095 and this part, such as submitting to the third party payer (or other entity involved in adjudicating a claim) any requests or documentation that